Medicaid Information Bulletin

OCTOBER 2000

Visit the Utah Medicaid Program on the Internet: www.health.state.ut.us/medicaid

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This bulletin is available in editions for people with disabilities. Call Medicaid Information: 538-6155 or toll free 1-800-662-9651.

00 - 80 Medicaid Provider Agreement Revised

The Division of Health Care Financing has been working closely with both public and private agencies and organizations to revise the Utah Medicaid Provider Agreement. The new agreement includes federal requirements and clarifies a provider's rights and responsibilities. The intent is to make existing rules more clear and to emphasize several rules which seem to be consistently misunderstood, such as payment in full, the

Internet site: www.health.state.ut.us/medicaid

Medicaid Information
- Salt Lake City area, call **538-6155**.
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free **1-800-662-9651**.
- From other states, call 1-801-538-6155.

Requesting a Medicaid publication or form?
Send the Publication Request Form attached.
- by **FAX: 1-801-536-0476**
- by mail to: Division Of Health Care Financing Box 143106, Salt Lake City UT 84114-3106

prohibition against billing Medicaid patients, disclosure of ownership, and records inspection. Federal requirements are based on the Balanced Budget Act, Americans with Disabilities Act, Civil Rights Act, and the Social Security Act.

UMA Statement on the Revised Provider Agreement

The Department of Health requested comments on the revised Medicaid provider agreement from many sources including the Utah Medical Association (UMA). In response to comments, the Department made numerous changes to the agreement. Some requested changes were not possible because of current federal law and regulation. Also, the Department recognizes that the UMA and others who commented may not have addressed all of the concerns individual physicians may have.

However, the UMA Board of Trustees feels the Department's process to obtain the views of as many interested groups as possible has been fair and inclusive. Individual physicians should carefully review the contract in light of their own circumstances to determine if they can accept its terms and conditions.

Comments Requested

Medicaid has extended the original implementation date for the new Provider Agreement to allow for additional comments. All comments will be reviewed and considered. A draft of the Provider Agreement is available on the Internet at: www.health.state.ut.us/medicaid/agreement.pdf. If you are unable to review the on-line copy, contact Medicaid Information, and a copy can be faxed to you.

You may e-mail, fax, or mail your comments. The e-mail address is: njohnson@doh.state.ut.us. The fax number is 1-801-536-0471. The mailing address is:

Bureau of Medicaid Operations
Attn: New Provider Agreement
PO Box 143106
Salt Lake City, UT 84114-3106

☐

00 - 81 American Family Care to Cover Four More Counties

Medicaid clients living in Cache, Iron, Kane and Washington Counties are now able to select American Family Care Plus (AFC+), an HMO, as their provider. Future expansion to other counties is planned. Clients who select this option have AFC+ printed on their Medicaid Card, and they must obtain services from participating AFC+ providers. For questions regarding this HMO, contact AFC+ at 1-888-483-0760. ☐

00 - 82 Altius No Longer Contracting with Medicaid

Effective October 1, 2000, Altius is no longer contracting with the Utah Medicaid Program. Medicaid clients formerly enrolled with Altius have been transitioned to other HMOs. We encourage you to resolve outstanding claims or other issues with Altius as soon as possible.

Their toll-free number is 1-800-377-4161. In Salt Lake County, call (801) 323-6200. Altius' e-mail address is customerservice@ahplans.com. ☐

00 - 83 Interpretive Services for Medicaid and UMAP clients

The Division of Health Care Financing has been negotiating contracts with five companies to provide interpretive services to Medicaid clients who have Limited English Proficiency (LEP). The contracts allow interpretive services to be available by phone 24 hours a day, 7 days a week, 365 days a year. Services cover almost 180 spoken languages. Also, the number of interpreters who are available for scheduled in-office interpretive services will increase.

The contracts cover interpretive services for Medicaid and UMAP clients who are not enrolled in a managed care plan. Clients who are members of an HMO must use the interpretive services offered by the HMO. Clients who are members of a Prepaid Mental Health Plan (PMHP) should continue to use the interpretive services provided by the Plan.

In November, we will publish details of the new contracts and procedures on the Medicaid web site. Look for the information on the page called "What's New":
www.health.state.ut.us/medicaid/html/what_s_new.html
The details will also be published in the next issue of the Medicaid Information Bulletin (January 2001), and you may contact Medicaid Information. ☐

00 - 84 Medicaid and Utah Statewide Immunization Information System (USIIS)

Utah Medicaid Program is a sponsor of and participant in the Utah Statewide Immunization Information System (USIIS). The USIIS is a confidential computerized immunization information system that will store immunization histories and provide Utah Medicaid providers with access to Medicaid children 's current immunization status and produce vaccination reports on Vaccine For Children (VFC) and Medicaid children. A fully functional USIIS will be a powerful tool to ensure that children receive timely immunization and proper treatment.

A new Utah administrative rule, R386-800, Immunization Coordination, was recently passed. The rule permits that all immunization records for all children can be entered into the USIIS and shared with authorized users. Records will automatically be entered in the USIIS from birth records (through an electronic linkage), by participating clinics where a child receives an immunization, and by other participating Medicaid providers. Records will be shared with authorized health care providers, health insurers, schools, day care centers, and public health programs. However, a child's parent or guardian may choose to withdraw from the system at any time.

When USIIS is fully operational, Medicaid providers will be strongly encouraged to enroll in USIIS. More information on USIIS will be available during the annual Medicaid Provider Training. For more information about USIIS, call 801-538-6872, or toll-free 800-275-0659. ☐

00 - 85 Child Health Measures: Correction to Results Announced

In the July Medicaid Information Bulletin, we reported on our Immunization Measure Project (Bulletin 00 - 69, Medicaid Announces the Results of Two Child Health Measures).

We incorrectly reported that we were only able to match 25 children in our sample with data in the Utah State Immunization Information System (USIIS). We were able to match **25%** of the children in our sample with data in USIIS. We are sorry for the incorrect number. For information on our project, please call Julie Olson at 801-538 - 6303 or send e-mail to jolson@doh.state.ut.us. ☐

00 - 86 Home Health Agencies: Prior Authorizations Are Provider Specific

In order to ensure that a service is appropriate or that Medicaid covers the service in a given situation, some home health services require prior approval by the Medicaid agency. These services are identified in SECTION 2 of the Utah Medicaid Provider Manual for Home Health Services and in Medicaid Information Bulletins. If a service requires prior authorization, the authorization must be obtained before the service is rendered, unless it meets one of the exceptions specified in the manual.

Prior authorizations for home health services are provider specific. This means that only the agency that applied for and received the prior authorization may use the authorization number. If another agency assumes responsibility for serving the patient, that agency must apply for and receive a separate prio r authorization.

Please note that a prior authorization is not a guarantee of payment. It is authorization for payment if all other conditions and requirements have been met.

Home Health Manual Updated

Home Health Providers will find attached pages 18 - 19 to update SECTION 2 of their Medicaid Manual. A vertical line on the page in the margin indicates where text was changed or added. An Index for SECTION 2 is also attached. ☐

00 - 87 Hyperbilirubinemia: Hospital Readmissions within 30 Day

Hyperbilirubinemia, or jaundice of the newborn, appears in a certain percentage of newborn infants within the first week of life. Symptoms vary from very mild to severe and life threatening. There is no way to predict which infants will develop symptoms of jaundice, and most infants are discharged from the hospital within a short time after birth.

According to the American Academy of Pediatrics, most healthy full term infants who develop jaundice may be safely managed as outpatients at home. However, the most severe cases require hospitalization. Since hyperbilirubinemia is not easily detected, and hospitalization may be necessary, readmissions within 30 days will be exempt from initial review, and a second DRG may be paid. This policy is effective October 1, 2000. Exception cases will be subject to random selection and review as part of the regular utilization management review process.

SECTION 2, Physician Services, Updated

A new item on hyperbilirubinemia is added to SECTION 2 of the Utah Medicaid Provider Manual for Physician Services, Chapter 3, Limitations. Providers of physician services will find attached pages 20 - 21 with the new item II, Hyperbilirubinemia: Hospital Readmissions within 30 Days. A vertical line in the margin of page 21 indicates where text was added.

SECTION 2, Hospital Services, Updated

SECTION 2 of the Utah Medicaid Provider Manual for Hospital Services, Chapter 3, Limitations, items 7 through 18 (pages 16 and 17), are reorganized to clarify inpatient and outpatient limitations. The new item 11, Exceptions to the 30-day readmission policy, includes the policy on Hyperbilirubinemia. Other items on the list of limitations which have been clarified are as follows:

- Inpatient rehabilitation or psychiatric patient off-unit pass
- Therapeutic leave of absence
- Review of inpatient "outlier days"
- Readmissions Within 30 days of Previous Discharge
- Laboratory services
- Occupational therapy services
- Outpatient Hospital Services
- Observation or treatment room services
- Outpatient hospital psychiatric services
- Non-physician psycho-social counseling services
- Services reimbursed in the Emergency Department

Hospital service providers classified as "General Hospital" will find three pages attached to update SECTION 2: Table of Contents, page 1; Limitations, pages 16 - 17; and the Index, page 22. A vertical line in the margin of the page indicates where text was changed or added. □

00 - 89 Anti-Ulcer Drugs: Preprinted Prescription Pad No Longer Required

Effective immediately, the preprinted Anti-Ulcer Drug prescription for the H-2s and the PPIs (Tagemet et al) is no longer required. The copy of this prescription blank has been removed from the Utah Medicaid Provider Manual for Physician Services and the Manual for Pharmacy Services. Orders for this form will no longer be filled.

Pharmacy Manual Revised to Delete Requirement

The Pharmacy Manual has been revised to delete the requirement for the preprinted Anti-Ulcer Drug prescription described in SECTION 2, Chapter 5 - 6, Anti-Ulcer Drugs. This chapter still has the text of former paragraph number 2 concerning over-the-counter forms of anti-ulcer drugs. Providers of pharmacy services will find attached three pages to update SECTION 2: pages 1, 24 - 25 and the Index. An asterisk (*) in the margin on page 25 indicates where text was deleted. The on-line pharmacy manual has also been updated.
www.health.state.ut.us/medicaid/html/pharmacy_manual.htm
□

00 - 90 Mental Health Centers: Quality Improvement

SECTION 2 of the Utah Medicaid Provider Manual for Mental Health Centers, Chapter 1 - 10, Quality Improvement, has been updated. Mental health centers will find attached pages 8 - 9 to update this chapter. A vertical line in the margin on page 8 indicates where text was changed. □

00 - 90 Speech and Language Program: Criteria for Cognitive Therapy for Adults

Prior authorization is required for cognitive therapy for adults. Criteria for approval are as follows:

1. Diagnosis of :
   a. CVA. Treatment must begin within 90 days of the incident, OR
   b. Traumatic Brain Injury. Treatment must begin within 18 months of the injury.

2. Speech therapy for cognitive purposes must be ordered by a physician and must include a plan of care. Speech therapy for cognitive disorders should typically begin after speech therapy for dysphagia and motor function speech issues have been addressed. The care giver, if possible, must attend the therapy sessions to receive instructions to work with the recipient and reinforce therapy and conduct repetitions with the patient.

3. Therapy is limited to 12 visits over 60 days and one per month for the next three months for a maximum total of 15 visits.

Bill for cognitive therapy using codes Y1011 to Y1013.

Speech and Language Manual Updated

The Utah Provider Manual for Speech and Language Services has been updated to include the criteria for cognitive therapy for adults. Providers will find attached five pages to update SECTION 2. A vertical line on the page in the margin indicates where text was changed or added.

- Table of Contents, page 1.
- Chapter 1 - 2, Billing, (page 2) updated to delete reference to Medicaid instructions for the HCFA-1500. Instead, providers should refer to instructions in accordance with SECTION 1, Chapter 11 - 9, Billing Medicaid, item 2, Paper Claims. (Internet address: www.health.state.ut.us/medicaid/SECTION1.pdf)
- New item B, Speech Therapy for Cognitive Therapy for Adults, is added to Chapter 2, COVERED SERVICES. (page 3A - 3B). Insert this new page before page 4.
- Index added (page 9). □

00 - 91 Waiver Services Added for Individuals with Developmental Disabilities or Mental Retardation

Services available under the Home and Community-Based Waiver Services for Individuals with Developmental Disabilities or Mental Retardation ("DD/MR Waiver") are listed below. Services that are underlined were added to the waiver effective July 1, 2000. For a detailed description of the services, please refer to the Utah Medicaid Provider Manual for Home and Community-Based Waiver Services for Individuals with Developmental Disabilities or Mental Retardation.

HCBWS Providers will find attached a copy of SECTION 2, pages 1 through 36, to update their manual. A vertical line on the page in the margin indicates where text was changed or added. An asterisk (*) indicates where text was deleted. Other providers who want a copy of the manual should contact the Division of Services for People with Disabilities or Medicaid Information.

Providers should keep SECTION 3, Form 520, and SECTION 4, Procedures for Adjusting Payment to Providers.

DD/MR Waiver Services

Underlined services were added effective July 1, 2000.

Support Coordination
Community Living Supports
Personal Assistance
Personal Emergency Response Systems (PERS)
Environmental Accessability Adaptations
Chore and Homemaker Services
Supported Employment
Site and Nonsite-Based Day Supports
Senior Supports
Transportation Supports
Latch Key Supports
Family Assistance and Support (Family Support)
Respite Care Supports
Self-Directed Supports
Educational Supports
Specialized Medical Equipment/Supplies/Assistive Technology
Specialized Supports

□

00 - 92 Criteria for Methylphenidate / Amphetamines for Adults with ADD/ADHD

The criteria for methylphenidate/amphetamines for adults for ADD/ADHD has been updated. One change concerns adults with pre-existing ADD/ADHD who move into the state. The other change takes into consideration recognized scales used to establish ADD/ADHD, such as the Utah Wender Rating Scale, Conner test scale, and a level 2 psychiatric evaluation by a psychiatrist or a psychologist.

Pharmacists and physicians will find attached pages 7 - 8 and 9 - 10 of the Drug Criteria and Limits List which include the new criteria. A vertical line in the margin of the pages dated October 2000 indicates where text was changed or added. ☐

00 - 93 Criteria for Coverage of Pediasure

Code Y9233, Pediasure is discontinued. Pediasure is available for children ages 10 and younger under code B4150 as a total nutrition with a telephone authorization. Like other enteral formulas, the following criteria apply to ALL nutrients are met:

1. Diagnosis related to need for enteral nutrition.
2. No other food intake/total nutrition.
3. Functional impairment; i.e. missing or non-functioning portions of the GI system.
4. Enteral nutrition given by NG, NJ, GT, JT.
5. Patient has neurological or psychological impairment that prevents swallowing, which is a functional impairment.
6. Doctor's orders: name of product, dose and frequency or total calories per day

Pediasure, as total nutrition or as a supplement, is available through WIC for children 5 years and under, but is not a benefit of the Medicaid program except as described above. ☐

00 - 94 Waiver Renewed for Individuals with Acquired Brain Injury Age 18 and Older

The Home and Community-Based Waiver for Individuals with Acquired Brain Injury Age 18 and Older was renewed for another five years effective July 1, 1999.

Four services were eliminated from the waiver because of lack of utilization. The services deleted were: Environmental Accessibility Adaptations, Chore Services, Behavioral Programming, and Rehab Therapies. Also, a modification was made to the definition of Supported Living. A new Assessment instrument, 817b Form, and Social History were approved by the federal Health Care Financing Administration for use with the waiver.

For a detailed description of services covered by the waiver, please refer to the Utah Medicaid Provider Manual for Home and Community-Based Waiver Services for Individuals with Acquired Brain Injury Age 18 and Older .

Waiver providers will find attached a copy of SECTION 2, pages 1 through 23, to update their manual. A vertical line on the page in the margin indicates where text was changed or added. Keep SECTION 3, Form 520, and SECTION 4, Procedures for Adjusting Payment to Providers. Other providers who want a copy of this manual should contact Medicaid Information.

If you have questions about covered services, please contact Kelli Polcha, Long Term Care Unit, at: (801) 538-7069. ☐

00 - 95 Medical Supplies: Revision of SECTION 2 and Medical Supplies List

The Utah Medicaid Provider Manual for Medical Suppliers, SECTION 2, and the Medical Supplies List have both been extensively revised. Changes are effective October 1, 2000.

~ Medical suppliers will find attached a revised SECTION 2 and the Medical Supplies List to update their manuals. Note: When replacing SECTION 2 and the Medical Supplies List, keep the DMERC lists in your Medical Supplies Manual.

~ Providers of physician services will find attached a revised Medical Supplies List to update the Utah Medicaid Provider Manual for Physician Services.

A vertical line in the margin of a page indicates where text was changed or added. An asterisk (*) indicates where text was deleted.

Changes to SECTION 2, Medical Supplies, include:

- policy clarifications regarding limitations and coverage.
- decubitus care, hospital beds, mattresses and surfaces.
- specialized and customized wheelchairs.
- general updates and revisions incorporating state administrative rules governing medical supplies and DME.

Medical Supplies List Revised

Code changes to the Medical Supplies List are itemized below by category on the list. Descriptors are abbreviated. Changes include the addition of new codes, changes in coverage for existing codes, and deletion of discontinued codes. All changes are effective October 1, 2000, unless indicated otherwise. For complete information regarding criteria for coverage and limits, refer to the updated list. To assist you in locating policy regarding a category of medical supply, policy references have been added to the Medical Supply List.

First Aid Supplies, Wipes, Swabs

New Codes; Changes in Criteria for Existing Code:

A4455 Adhesive Remover
A4554 Disposable underpads. (Not for bed wetting)
A4565 Sling
A4590 Special Casting Material (Fiberglass)
Y6072 Pads . . . . limit of 156 per month

Stockings, Limits Added:

A4490 - A4510, Surgical stockings. Limit of 2 pair every 6 months

Ostomy Supplies

New Codes:

A4369 Skin barrier. Limit of 4 per month
A4370 Skin barrier . . . Limit of 4 oz per month
A4371 Skin barrier . . . Limit of 4 oz per month
A4372 Skin barrier . . . Limit of 10 per month
A4373 Skin barrier, with flange . . .
A4375 Pouch, drainable . . .
A4376 Pouch, drainable . . .
A4377 Pouch, drainable . . .
A4378 Pouch, drainable . . .
A4379 Pouch, urinary . . .
A4380 Pouch, urinary . . .
A4382 Pouch, urinary . . .
A4383 Pouch, urinary . . .
A4384 Ostomy faceplate equivalent . . .
A4388 Pouch, drainable . . .
Y6004 4 oz. Mini infant drain pouch. Limit of 10 per month

Code Discontinued April 1, 2000:

A4363 Skin barrier ... (replaced by A4369)

Codes Discontinued October 1, 2000:

A4362 Skin barrier . . . (replaced by A4372)
A5061 Pouch, drainable (no replacement)
A5064 Pouch, drainable (replaced by A4375)
A5065 Pouch, drainable (replaced by A4376)
A5071 Pouch, urinary (replaced by A4377)
A5074 Pouch, urinary (replaced by A4378, A4379)
A5121 Skin barrier; solid, 6x6 or equivalent
A5122 Skin barrier; solid, 8x8 or equivalent
A5123 Skin barrier: with flange (replaced by A4384)

Miscellaneous Supplies, New Codes:

A4614 Peak expiratory flow rate meter . . . Limit of 1 per year
Y0470 Artificial Nose . . . . Limit of 4 per month
Y0471 Artificial Nose tubing. Limit of 3 per month
Y5555 Enuresis Alarm. Requires prior approval. Limit of one per lifetime
Y5999 Quidel Quickview one-step Hpylori test kit.

Enteral, Parental Nutrition

New Codes; PA Requirement for Existing Code:

B9006LR Parenteral nutrition pump... Now requires written prior approval

Enteral, Parental Nutrition , continued

Y0440 Enteral Food addition . . .
Y4025 Mic-key/button for gastric. Limit of 1 every 2 years
Y4026 Mic-key/button tubing inclusive

Code Discontinued October 1, 2000:

Y9070 Pedialyte/Pediasure (Refer to Medicaid Bulletin 00 - 93, Criteria for Coverage of Pediasure.) Pedialyte has an NDC number.

Nutrients

Examples of formulas added to B4150, B4152, B4153, and B4154, Enterat formulas. Examples for B4150 include Pediasure, as per Bulletin 00 - 98, Criteria for Coverage of Pediasure.

Pumps

Changes to Criteria for Existing Codes:

Category 3: Stationary pumps

B9006LR Parenteral nutrition pump. . . Now requires written prior approval
Y0472LR Pump with cartridge . . Replacement cartridge included in rental.
Y0436 Cartridge for pancreatic pump; only for patient owned pump

New Codes:

Category 4: Semi-stationary or ambulatory pumps

E0779 Ambulatory infusion pump, reuseable. One time only.
E0780 Ambulatory infusion pump, reuseable. One time only.

Codes Discontinued October 1, 2000:

Y4020 pump (replaced by E0779, E0780)

NOTE: Discontinued codes E0452 and E0453 are replaced by K0532, respiratory assist device, in category Oxygen and Related Respiratory Equipment.

Bathroom Equipment, **New Codes:**

Y6046 Position support bath system. Requires prior authorization. 1 per lifetime
Y6079 Toilet Seat, Support/reducer ring. Requires prior authorization. 1 every 5 years

Decubitus Care, New Codes:

E0192 Low pressure/positioning equalization pad . ..
Y5998 pressure relieving mattress (Atmosair type). Requires prior authorization.
Y6001LR Water fluidation bed. Clarifies rental is per day.
Y6016 Chaston Gauze conforming

Oxygen & Related Respiratory Equipment

PA Requirement Added to Existing Code:

K0531 Humidifier, heated. . . Now requires written prior approval

New Codes:

K0532P or LR; K0533P or LR: Respiratory assist devices. Require prior authorization. If purchased, one per lifetime.
Y0587 CPAP tubing for patient owned BiPAP . Under contract to single provider only
Y6071 Overnight reading/oximeter . . .
Y6605LR, Y6610LR Oxygen concentrators . . . . Under contract to single provider only

Codes Discontinued October 1, 2000:

Y6050 cove (replaced by Y6050LR)
Y6615 cove and port (replaced by Y6050LR)

Humidifiers and Nebulizers

PA Requirement Added to Existing Code:

K0531 Humidifier, heated. . . Now requires written prior approval

New Codes:

Y6005 Tracheostomy ties/twill tape . . .
Y6095 Pari LC jet nebulizer/pari proneb comp. Requires prior authorization. Limit of one unit
Y6103 Speaking valve Tracheostomy

Suction Pumps and Room Vaporizers, **New Code:**

Y6051 In-line suction catheter . . . Limit of 25 per month

Patient Lifts and Traction Equipment, **New Code:**

Y6066 Head harness pulley system. Requires prior authorization.

Wheelchair and Wheelchair Accessories, **New Codes:**

Y0556 Extension tubes. For ages 0 - 20 only. Requires prior authorization.
Y6006 Tilt in space wheelchair. For ages 0 - 20 only. Requires prior authorization.
Y6129 Shoe Holder, each. For ages 0 - 20 only. Requires prior authorization.
Y6131 Full Anterior positioning chest support. For ages 0 - 20 only. Requires prior authorization.
Y6136 Contour U back or seat hardware. Requires prior authorization.
Y6144 Multi-chamber, air pocket, ROHO cushion

Wheelchair Replacement Supplies

New Codes:

K0082, K0083 Wheelchair batteries . . . Require prior authorization. Limit of 2 batteries per year

K0085 Gel battery. Requires prior authorization. Limit of 2 batteries per year

Codes Discontinued October 1, 2000:

Y0555 Gel battery (replaced by K0085)

Y0568 Wheelchair battery, 22 NF lead acid (replaced by K0082)

Y0570 Wheelchair battery, 22 NF gel (replaced by K0083)

Repairs and Durable Medical Equipment, Not Classified, **Change in Age Requirement:**

E1399 Durable medical equipment, miscellaneous. For all ages. Requires prior authorization.

Pneumatic Compressor and Appliances, **New Code:**

Y1499 Lymphedema sleeve and gauntlet. Requires prior authorization.

Lower Limb: Hip, Knee, Ankle, **New Code:**

L1906 Ankle-foot orthosis, multi-ligament ankle support

Upper Limb, **Change in Criteria:**

L3675 Shoulder orthosis. . . . Requires prior authorization, criteria changed.

Prosthetics, Lower Limb, **New Code:**

L5910 Addition, endoskeletal system, below knee . . . Limit of 1 every 5 years

Repair Prosthetic Device, **New Code:**

L7520 Repair, of prosthetic device . . . Requires prior authorization. Limit of 2 hours per year

Prosthetic Sock, **New Code:**

L8435 Prosthetic sock . . .

Hearing Aids, **New Code:**

V5299LRHearing aid loaner. Requires prior authorization. 2 month maximum.

□

00 - 96 Dental Program: Clarifications and Changes

This bulletin describes or clarifies coverage of dental exam codes. Dental providers will find attached a replacement for SECTION 2 of the Utah Medicaid Provider Manual for Dental Care Services. (When replacing SECTION 2, be sure to keep the last page which is the 1991 ADA form instructions.) A vertical line on the page in the margin indicates where text was changed or added. The remainder of this bulletin briefly describes changes in the following chapters of SECTION 2.

Chapter 1 - 5, Diagnostic Services

Medicaid will reimburse for one exam (D0140, D0120, or D0150) per patient per day, even if more than one provider is involved from the same office or clinic. **Multi-exams for the same date of service are not covered.**

The standard practice for code D0140, Limited oral evaluation - problem focused, is to not allow this to be billed with any other exam code on the same patient, same provider or same clinic, on the same date of service. This is inherent in the code itself. From the ADA CDT-3 manual:

> **D0140, limited oral evaluation - problem focused.** *An evaluation limited to a specific oral health problem. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately . Definitive procedures may be required on the same date as the evaluation.*

Medicaid considers this an emergency code. Medicaid will allow this code with x-rays, extractions (if the extraction relieves the pain or problem), fillings (only if one or two fillings are done, to relieve pain, etc.), other procedure to relieve pain for an emergency situation. It is not to be billed with numerous fillings, multi-tooth extractions, prophylaxis and fluoride treatments, routine filling appointments, root canals, relines, denture appointments, any routine or regular appointment, etc. It is by definition a problem-focused exam – essentially an emergency exam. Indiscriminate use of this code is considered over utilization and abuse.

Chapter 1 - 6, Radiographic Services

Medicaid considers it standard practice to bill for a full mouth series if more than nine (9) periapicals are taken during a single visit.

Chapter 1 - 7, Preventive Services

Oral debridement may be done once per year and in conjunction with a prophylaxis in cases requiring subgingival scaling.

Chapter 1 - 8, Restorative Services

Medicaid will **not** reimburse for a primary stainless steel crown, D2930, and alloy or composite fillings for the same tooth, same date of service. Bill for one or the other, but not both procedures. It is **not** allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown on a primary tooth.

Medicaid will not reimburse for a permanent stainless steel crown, D2931, and alloy or composite fillings for the same tooth, same date of service. It **is** allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown – permanent.

Chapter 1 - 9, Endodontics

Root canal therapy is covered benefit excluding third molars. Second and third molars are also excluded for adults.

Billing Medicaid for Completed Root Canal

Root canals are to be billed after the canals have been completely obturated with the final filling. Billing Medicaid for services which have not been completed is not allowed.

Billing the Patient when Root Canal is Incomplete

Occasionally, dental patients have the first stage endodontic procedure done for pain relief and fail to return for subsequent appointments. Even though the provider has rendered services, he cannot bill Medicaid for a completed root canal. If the patient will not return so the root canal can be completed, the dentist may consider whether or not the patient can be billed.

The provider may bill the Medicaid patient ONLY WHEN he scrupulously follows the process described in SECTION 1, of the Utah Medicaid Provider Manual, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients. This policy requires the provider to have a written agreement with the patient regarding services not covered by Medicaid BEFORE service is rendered. when a root canal is initiated. To assist providers, we added reminders of the prohibition on billing patients, and two exceptions, to Chapter 1 - 9, Endodontics.

Dentists may want to consider having the required, written agreement with the patient regarding billing for non-covered services in advance of treatment, in the event the patient fails to return and Medicaid cannot be billed. The agreement may also help prevent no-shows for root canal appointments.

Chapter 1 - 10, Periodontics

A "gross debridement", code D4355, is available one time per year.

Chapter 1 - 11, Prosthodontics

Medicaid covers only hard relines completed by a laboratory. It is difficult to establish a time for a reline following an immediate denture, but typically, hard relines should be delayed until bone resorption has stabilized following the extractions which would be 6 to 12 months following the extractions. Medicaid will not pay for more than two relines per year per arch.

Chapter 1 - 17, I.V. Sedation

I.V. sedation requires prior authorization when performed by a nurse anesthetist.

Chapter 1 - 19, Oral Sedation

Medicaid covers intramuscular and intra oral injections for sedation only under code D9248, non-intravenous conscious sedation, which includes the sedative drug.

Chapter 2, NON-COVERED SERVICES

Three specifically non-covered items added as numbers 24 - 26. These are:

a. Limited orthodontic and removable appliance therapies.
b. Removable appliances in conjunction with fixed banded treatment.
c. Habit control appliances.

Chapter 3, DENTAL SPEND-UPS

Policy is clarified as to determining the fee when a Medicaid client chooses to upgrade a covered service to a non-covered service. Generally, a provider may not bill a Medicaid patient for the difference between the Medicaid payment and the provider's usual and customary fee, as the Medicaid payment is considered payment in full. However, when a patient requests a service not covered by Medicaid, such as a non-covered composite resin filling instead of a covered silver filling, a provider may bill the Medicaid patient when ALL FOUR conditions of SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services, are met.

The only dental procedures which a Medicaid client may choose to upgrade are listed. The client must agree to assume the responsibility for the difference in the fees for the covered and non-covered services.

Chapter 5, DENTAL PROCEDURE CODES, LIMITS AND CRITERIA

Policy references are added to each set of dental care codes. Providers are responsible to ensure all criteria for use of code and billing are met, whether the criteria are specified in policy in Chapter 1, Covered Services, or on the coding tables in Chapter 5. As the manual is revised, criteria will be consolidated on the coding tables. At this time, however, the provider must refer to both the policy cited and the table to ensure compliance and coverage.

Code changes are listed below by category. Descriptors are abbreviated. Changes include the addition of new codes, changes in coverage for existing codes, and deletion of discontinued codes. All changes are effective October 1, 2000, unless indicated otherwise. For complete information regarding coverage and limits, refer to the updated list.

Preventive Services
Clarify that D1110, Prophylaxis - adult and D1120, Prophylaxis - child are two per calendar year **per provider.**

Restorative Services
Change criteria for D2930 and D2931, Prefabricated stainless steel crown - permananent teeth, in accordance with policy in Chapter 1 - 8, Restorative Services.

Endodontics
Clarify criteria for D3330, Endodontic therapy - Molars, in accordance with policy in Chapter 1 - 9, Endodontics.

Periodontics
Clarify criteria for D4355, Full mouth debridement, periodontal evaluation, in accordance with policy in Chapter 1 - 10, Periodontics

Prosthodontics
Clarify criteria for D5750, Reline complete maxillary denture (laboratory), and D5751, Reline complete mandibular denture (laboratory), in accordance with policy in Chapter 1 - 1, Prosthodonfics.

Orthodontia
Add code D8680, Orthodontic retention. Prior approval required.

INDEX, Alphabetical and Numerical by Code

A second index has been added to SECTION 2. The new index lists dental codes in numerical order and the pages on which the code can be found.

Instructions for Completing ADA Dental Claim Form 1999 Version 2000

Instructions for completing the ADA Dental Claim Form 1999, Version 2000, are being added to the Utah Medicaid Provider Manual for Dental Care Services.

SECTION 2, Dental Care Services, Updated

Dental care providers will find attached SECTION 2, pages 1 - 31, to update their manual and the year 2000 instructions for the new version of the ADA Dental Claim Form . Keep the 1991 ADA Form Instructions.

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00 - 97 Obtaining Copies of Federal Regulations

You may obtain a copy of federal regulations published in the Federal Register from several sources. Copies are available from the following web sites:

www.access.gpo.gov/su_docs/aces/aces140.html

http://aspe.hhs.gov/admnsimp

To order printed copies of the Federal Register, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date of the issue requested, and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each copy is $8.

As an alternative, you can view and photocopy the Federal Register document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries which receive the Federal Register. □

00 - 98 Electronic Copies of Medicaid Information Bulletins and Index

Medicaid Bulletins published since April 1997 are on the Internet. You can find the links to both the current and past bulletins at:

www.health.state.ut.us/medicaid/html/provider.html

There is also an Index to Medicaid Information Bulletins on the Internet. The Index has an alphabetical list of articles by keywords and title and also a chronological list of bulletins by date published. The Index is at:

www.health.state.ut.us/medicaid/IndexMIBs.pdf

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00 - 99 Client Information and Education

Articles sent to Medicaid clients in the quarterly newsletter Clientell are published on the Internet. Copies of the articles are available on the Internet at www.health.state.ut.us/medicaid/html/clientell. Copies may be printed and freely distributed for nonprofit, educational purposes. An index of articles is on the Internet at: www.health.state.ut.us/medicaid/html/clientell_index.htm.

Below is a list of Clientell articles sent recently to Medicaid clients. Also, for those unfamiliar with Medicaid's monthly newsletter, there is information about the newsletter at the end of this bulletin.

September 2000

- HMO Update - Altius no longer part of the Utah Medicaid program
- Immunizations and well-child checkups
- Avoid Problems With Medical Bills!
- Hotline Resources in the Utah Department of Health: Check Your Health, Medicaid Information, Baby Your Baby, CHIP, Immunize by Two, Baby Watch Program.

Medicaid Client Newsletter Clientell

The Clientell is a quarterly publication by the Division of Health Care Financing which is mailed to all households receiving a Medicaid card. The purpose is to educate and inform clients of Medicaid policies, procedures and other issues. It is also a tool to share community resources.

Articles will be compliant with the Medicaid information and communication requirements of the Balanced Budget Act of 1997 (BBA). That act requires states to provide information about Medicaid managed care that is easy for clients to understand. The Utah Medicaid population is a very diverse group of people. Our goal is to make the information easily understood and sensitive to literacy barriers and cultural differences in this population.

We welcome suggestions for articles from providers and other interested parties. The editor of the Clientell is Randa Pickle, Consumer Advocate for the Division of Health Care Financing. Please call 1-877-291-5583 or e-mail suggestions to rpickle@doh.state.ut.us. □